Salmeterol therapy in mild asthma

Sir,

The study by Hyland and colleagues (May *Journal,* p.214) showed that salmeterol therapy improved the quality of life of a group of patients with mild asthma (63.1% of patients improved with salmeterol, while 46.6% of patients improved with placebo). It would be logical that such a group of patients would feel better with additional bronchodilator therapy, whether it be xanthines, salmeterol or controlled-release salbutamol. It would be more appropriate, however, and in keeping with the British Thoracic Society guidelines,[1] to treat them with increased doses of anti-inflammatory drugs such as disodium cromoglycate or inhaled steroids.

The cost implications of using salmeterol to attain this marginal improvement in quality of life for people with asthma are enormous. In 1988 the total drugs bill for all asthma drugs was £228m.[2] It is estimated that if only half of the asthma sufferers in the United Kingdom were prescribed the recommended dose of salmeterol, the cost would be an additional £380m per annum. There is a place for salmeterol in the management of asthma but surely it is not to patch up the inadequate use of existing prophylactic therapy.

P G WEAVING

The Surgery
Brampton
Cumbria CA8 1NL

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Asthma care in general practice — time for revolution?

Sir,

Dr Jones confidently expects to witness a revolution in asthma care in the 1990s (June *Journal,* p.224). While treatment guidelines which are adhered to are a step forward,[1] they cannot provide the complete solution. A major restraint to providing appropriate treatment in adults is the difficulty in differentiating asthma from the other disorders that lead to airways obstruction.

This issue of diagnostic confusion was addressed in a survey of 2387 patients aged 40–70 years registered with an urban general practice.[2] There was considerable overlap in clinical and physiological features (including airways reversibility) between patients reporting diagnostic labels of asthma, chronic bronchitis and acute bronchitis. Furthermore for every patient with a diagnosis there were two to three other patients with similar symptoms with no diagnostic label. The diagnosis was important as wheezing patients labelled as asthmatic were three times more likely to be prescribed appropriate treatment than those labelled as chronic bronchitics and 12 times more likely to be prescribed appropriate treatment than those without a diagnostic label.[3]

An important step in making the diagnosis of adult asthma easier would be the introduction of a standardized nomenclature based on agreed criteria. The continuation of the opposing views expressed by followers of the Dutch[4] and British[5] theories of asthma aetiology suggest that this is unlikely. This inability to agree on what constitutes asthma will probably delay the treatment revolution in adults. This is worrying as most asthma deaths occur in the older age groups.[6]

P LITTLEJOHNS

Department of Public Health Sciences
St Georges Hospital Medical School
Cranmer Terrace
London SW17 0RE

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Which antidepressant?

Sir,

The discussion paper from Drs Matthew and Eagles (March *Journal,* p.123) provoked considerable discussion at our regular psychiatry liaison meeting. We came to rather different conclusions about the 'best buy' antidepressants in general practice. My partner and I meet our visiting psychiatrist every month to discuss the general practice management of patients with psychological and psychiatric problems. Our psychiatrist also holds a regular clinic based in our health centre.

Many otherwise fit patients without cardiovascular or urinary problems find that tolerance to the side effects of tricyclic antidepressants soon develops. Thus, in younger patients, the side effect profile of the older antidepressants need not be a bar to their regular use. We consider it reasonable to reserve the newer antidepressants for those who cannot tolerate the side effects of tricyclic antidepressants, and for the elderly in whom the risks are greater.

In addition, we were uncertain as to whether 'fatal poisoning per million prescriptions' was the most appropriate guide to problems of overdose. In severe or acute depression we would be punctilious about prescribing only small quantities of toxic drugs, with close monitoring of treatment and careful follow up. It is always difficult to predict which patients will attempt suicide, but exploration of any suicidal ideation and restriction of prescribing to small quantities will surely go far to reducing fatal overdoses.

Thirdly, while fluoxetine and fluvoxamine do indeed inhibit serotonin, they are extremely expensive drugs. Clomipramine also has 5-HT blocking properties, is much cheaper and can be used safely in general practice for those patients who have severe mixed anxiety and depression. A consultant referral is not mandatory in such cases.

In summary, there is still a place for the first generation of antidepressants, the newer agents being reserved for those in whom side effects are a serious problem or treatment with the older agents has failed.

AVRIL DANCZAK

Alexandra Park Health Centre
2 Whitswood Close
Alexandra Park
Manchester M16 7AW

Sampling endocervical cells on cervical smears

Sir,

We were interested to read the paper from the Cumbrian Practice Research Group (May *Journal,* p.192) comparing the Aylesbury spatula with the Cervex® cervix brush sampler. We have just completed a survey of 50 patients in our practice which differed methodologically in three respects: each patient had two samples taken, one with each instrument; only one operator performed the smears; and all the smears were read by one person at the laboratory on a blind basis.

The laboratory conclusions were as follows: two of the specimens taken with the cervix brush had endocervical cells present, while the corresponding smears